DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF OCCUPATIONAL SAFETY AND HEALTH
TICF CREDIT CARD PAYMENT FORM

DATE: _____ **WCIRB#:** _____
(MM/DD/YYYY)

EMPLOYER NAME: _____

DBA: _____

BILLING ADDRESS: _____

EMPLOYER PHONE NUMBER: _____

BILLING NOTICE # _____ **ASSESSMENT AMT DUE**: _____

CALLER NAME: _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

CREDIT CARD INFORMATION:

TYPE OF CREDIT CARD: (Check one) ☐ VISA ☐ MASTERCARD

CREDIT CARD NUMBER: _____

SECURITY CODE (3-digit number shown on back of card after credit card no.): _____

EXPIRATION DATE (mm/yy): _____

NAME ON CREDIT CARD (Please print): _____

PAYMENT AMOUNT: _____

AUTHORIZATION AMOUNT (Optional): _____

SIGNATURE AUTHORIZING PAYMENT: _____

PLEASE SEND CONFIRMATION BY: (Check one) ☐ FAX ☐ EMAIL

PLEASE FAX THIS FORM TO (415) 703-3037

FOR USE BY DIR ACCOUNTING ONLY:

PREPARED BY: _____

AUTHORIZATION NUMBER: _____

DATE AUTHORIZED: _____ TAKEN BY PHONE: *Volume License Software*